Clear Form

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
STATE OF IOWA LIFE INSURANCE ENROLLMENT FORM

THE HARTFORD

☐ Initial ☐ Change ☐ Termination ☐ Reinstatement

TO BE COMPLETED BY THE EMPLOYEE

Name: Last	First	M.I.
Social Security Number	Sex ☐ M ☐ F	Birth Date (MM/DD/YYYY)
Employee Home Address: (Street	City State	Zip Code)

The State of Iowa provides, at no cost to you, **Basic Life and AD&D Insurance** in an amount equal to $20,000. Please see your Personnel Assistant for further information.

You may enroll in the State of Iowa's **Supplemental Life and AD&D Insurance** plan. You may only elect coverages reflected in the Group Policy underwritten by Hartford Life and Accident Insurance Company. To elect coverage check the box marked "Y" and indicate the amount of insurance. To decline coverage check the box marked "N."

Supplemental Life and AD&D

☐ Y Amount $ _____ ☐ N

BENEFICIARY DESIGNATION - Please refer to the reverse side of this form for important information regarding beneficiary designation.

It is important that you designate a beneficiary for your Basic Life and AD&D Insurance even if you are not enrolling in Supplemental Life and AD&D Insurance. The beneficiary designation can be changed at any time by you. If you are married or divorced, you should consult with your legal counsel prior to changing your beneficiary. The designation takes effect as of the date you signed and dated the form.

PRIMARY BENEFICIARY

Full Name		Address (Street City State Zip)	
Social Security Number	Relationship	Date of Birth	Benefit Percent: %

CONTINGENT BENEFICIARY

Full Name		Address (Street City State Zip)	
Social Security Number	Relationship	Date of Birth	Benefit Percent: %

☐ I hereby apply for the Supplemental Life and AD&D coverage I have indicated above, and I authorize my Employer to make the appropriate deductions, if any, from my wages for my share of the cost. I understand that the coverages available to me are in accordance with the provisions of the contract between The Hartford and my Group Plan.

☐ I hereby waive the Supplemental Life and AD&D coverage offered to me. I understand that if I desire to apply for this coverage at a later date, I will be required to furnish, at my own expense, medical evidence in support of insurability, that is satisfactory to The Hartford, before my coverage will become effective.

Signature _____ **Date** _____

TO BE COMPLETED BY THE EMPLOYER

Policy Number	Bill Unit	Claim Unit	Employee Branch	Original Effective Date of Policy
41-ADD-S07951	**001**			**01/01/2008**

Employer Name	Employee Hire Date	Effective Date of Coverage	Reinstatement Date
State of Iowa			

NAMING YOUR BENEFICIARY

It is important that your beneficiary designation be clear so that there will be no question as to your meaning. It is also important that you name a primary and contingent beneficiary. When naming your beneficiary (ies) please indicate their full name, address, social security number, relationship and, if a minor, the age of that minor. If the beneficiary is not related either by blood or marriage insert the words, ***"Not Related."*** If you need assistance, contact your company representative or your own legal counsel.

Be sure that your intentions are clear and that you have included your name, your Social Security Number, the group name, (State of Iowa), the policy numbers, and that you have signed and dated all forms and Beneficiary Designations.

If you name more than one beneficiary with equal shares, please show the amount of insurance to be paid to each beneficiary in fractional parts, for example "1/3 to Mary Jones, Mother and 2/3 to Edith Jones, Wife."

If you find that more space is needed for naming your beneficiary (ies) than that provided on this form please complete a Beneficiary Designation Form GR-11927.